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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **JENNIFER JANE COVEY, A.K.A.** **JENNIFER JANE JONES** **773 Sequoia Ave.** **San Mateo, CA 94403** **Registered Nurse License No. 305299** Respondent.	Case No. 2011-516 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about August 31, 1979, the Board of Registered Nursing issued Registered Nurse License Number 305299 to Jennifer Jane Covey, A.K.A. Jennifer Jane Jones (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on May 31, 2011, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2750 of the Business and Professions Code ("Code") provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2761 of the Code states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

. . ."

6. Section 2762 of the Code states:

"In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

. . .

"(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section."

7. California Code of Regulations, title 16, section 1442, states:

"As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single

situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

8. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license.

9. Section 118, subdivision (b), of the Code provides that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued or reinstated.

10. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

DRUGS

11. Morphine is a Schedule II controlled substance as designated by Health and Safety Code section 11055(b)(1)(M), and a dangerous drug as designated by Business and Professions Code section 4022. It is used to treat moderate to severe pain.

FACTUAL BACKGROUND

12. On or about May 15, 2007, Respondent was employed by Mission Hospice in San Mateo, California, as a hospice nurse. She was assigned a 90 year-old patient, A.S., who was admitted to Brookside Skilled Nursing Facility on April 2, 2007 as a result of a fall. A.S. suffered from hypothyroidism, hypertension, aortic stenosis and renal insufficiency. On or about May 15, 2007, patient A.S. had confusion and shortness of breath. At 20:30 on May 15, 2007, patient A.S.'s physician ordered morphine .5 ml (milliliters) (10 mg) administered orally every hour for shortness of breath. Respondent went to the pharmacy and obtained 30 ml of morphine for A.S.

13. According to the nurse's medication notes, Respondent administered morphine to patient A.S. three times on May 15, 2007 as follows:

18:15: 20 mg

18:30: 20 mg

19:00: 10 mg[1]

However, according to the nurse's notes, Respondent only administered morphine to patient A.S. one time on May 15, 2007 as follows:

18:15: 20 mg

Respondent's typewritten "Nursing Note for 5/15/07" indicates that morphine was administered to A.S. four times:

17:45: 20 mg

18:15: 20 mg

18:45: 20 mg

19:30: 20 mg

14. At 20:00 on May 16, 2007, A.S.'s physician ordered .5 ml (10 mg) of morphine every 30 minutes orally as needed for shortness of breath. According to the nurse's notes, patient A.S. was administered morphine on May 16, 2007 as follows:

14:45: 20 mg

15:15: 20 mg

15:30: 10 mg

16:00: 10 mg

16:20: 10 mg

15. When Respondent received the morphine from the pharmacy on May 15, 2007, it contained 30 ml of morphine. When she returned the morphine to a nurse at Brookside Skilled Nursing Facility on May 16, 2007, it had 10 ml remaining in the bottle. Respondent failed to document or account for the disposition of the missing morphine. Patient A.S. died on the morning of May 17, 2007.

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[1] Respondent reported that due to A.S.'s combativeness, an unknown quantity of morphine was pushed out of A.S.'s mouth during administration of the morphine.

FIRST CAUSE FOR DISCIPLINE

(GROSS NEGLIGENCE)

16. Respondent is subject to disciplinary action under section 2761(a) in that she was grossly negligent when she administered morphine to Patient A.S. on May 15, 2007 in excess of the amount prescribed, as alleged above in paragraph 13.

17. Respondent is further subject to disciplinary action under section 2761(a) in that she was grossly negligent when she administered morphine to Patient A.S. on May 15, 2007 more frequently than once an hour, as alleged above in paragraph 13.

18. Respondent is subject to disciplinary action under section 2761(a) in that she was grossly negligent when she administered morphine to Patient A.S. on May 16, 2007 in excess of the amount prescribed, as alleged above in paragraph 14.

19. Respondent is further subject to disciplinary action under section 2761(a) in that she was grossly negligent when she administered morphine to Patient A.S. on May 16, 2007 more frequently than once every hour, as alleged above in paragraph 14.

SECOND CAUSE FOR DISCIPLINE

(FALSIFIED, GROSSLY INCORRECT OR UNINTELLIGIBLE RECORDS)

20. Respondent is subject to disciplinary action under section 2762(e) in that she falsified, or made grossly incorrect, grossly inconsistent, or unintelligible entries in A.S.'s medical record, as alleged above in paragraph 13.

21. Respondent is subject to disciplinary action under section 2762(e) in that she falsified, or made grossly incorrect, grossly inconsistent, or unintelligible entries in A.S.'s medical record, as she failed to account for the missing morphine.

22. Respondent is subject to disciplinary action under section 2762(e) in that she falsified, or made grossly incorrect, grossly inconsistent, or unintelligible entries in A.S.'s medical record, as she failed to account for any spillage due to A.S.'s combativeness.

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PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 305299, issued to Jennifer Jane Covey, A.K.A. Jennifer Jane Jones;

2. Ordering Jennifer Jane Covey to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 12/10/10

Louise R. Bailey

LOUISE R. BAILEY, M.ED., RN
~~Interim~~ Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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